

## Chapter Ins 16

## REGULATORY STRUCTURES

Ins 16.01 Annual billings for the examination of domestic insurers

**Ins 16.01 Annual billings for the examination of domestic insurers.** (1) **PURPOSE.** The purpose of this rule is to develop a framework for the regular annual billing of domestic insurers, (except for town mutuals), to fund the costs of administering examinations as prescribed by section 601.44, Wis. Stats., and to interpret section 601.45 (1), Wis. Stats.

(2) **SCOPE.** The billing structure established by subsection (5) shall apply to all domestic insurers as defined by section 600.03 (27) (c), Wis. Stats., with the exception of town mutuals.

(3) **CLASSIFICATION OF DOMESTIC INSURERS.** For the purposes of this rule, domestic insurers other than town mutuals shall be classified into the following categories:

(a) Insurers authorized to issue property and casualty insurance as defined in section Ins 6.75 (2), including the state property insurance fund;

(b) Insurers authorized to issue life and disability insurance as defined in section Ins 6.75 (1), including the state life insurance fund;

(c) Service insurance corporations and other insurers authorized under chapter 613, section 185.981 or section 185.991, Wis. Stats.; and

(d) Fraternal benefit societies authorized under chapter 614, Wis. Stats.

(4) **BILLING FOR EXAMINATION CHARGES.** (a) On February 1, 1978, and annually thereafter, each domestic insurer subject to the provisions of this rule shall be billed an amount equivalent to such insurer's share of the estimated cost of conducting the insurer examinations program during that year.

(b) All other insurers, including town mutual insurers, shall be billed on a charge-back basis for the full cost of their examinations, including actual salaries and expenses of examinations and other apportionable expenses.

(5) **BILLING STRUCTURE.** (a) The commissioner shall annually, prior to the first day of each calendar year, estimate the cost of administering the insurer examinations program for the next calendar year. This amount shall be based on the biennial budget as approved by the legislature. Included in the estimated cost of administering the insurer examinations program shall be:

1. Salaries, fringe benefits and expenses of insurer examinations staff, including office overhead;

2. Supplies, office space, training costs, related data processing charges; and

3. A contingency fund for hiring outside consulting or technical services.

(b) Excluded from this amount shall be the estimated share of the costs of the examination function which shall be provided through funding by insurers who will be charged for their examinations on a charge-back basis.

(c) In the event that the sum of a year's billing under this rule exceeds the actual cost of administering the insurer examinations program, the amount of the excess shall be applied as an offset to the estimated cost for the next year's examinations program.

(6) ACCOUNTING SUMMARY. On or before January 31 of each year, an accounting summary of the previous calendar year's examination costs shall be prepared. This summary will be furnished upon request to those insurers subject to this rule.

(7) DETERMINATION OF INDIVIDUAL BILLINGS. In determining the proportionate amount to be billed each domestic insurer subject to this rule, the commissioner shall:

(a) Take into account the following types of factors, based upon the insurers' status as of December 31, of the second preceding calendar year:

1. Size of insurer;
2. Type of business;
3. Category of insurer under subsection (3);
4. Premium volume;
5. Historical examination experience; and
6. Such other factors as may be deemed appropriate.

(b) Review the pattern of examination costs over previous years, and calculate the proportion of regular examination charges applicable to each of the 4 categories of insurers listed in subsection (3).

(c) Within each of the 4 categories of insurers listed in subsection (3), analyze the relationship between the costs of past regular examination billings, the amount of assets and the amount of premiums of domestic insurers, to mathematically determine a line of best fit formula for that category of insurers, which shall then be applied uniformly to all insurers in that category.

(8) LIMITATIONS ON AMOUNT OF BILLINGS. The annual bill for each insurer subject to this rule shall be determined utilizing the formula developed for the category of insurance to which it belongs, for its proportionate share of cost of the examination function, under the procedure outlined in subsection (7), except that:

(a) The maximum annual billing for any insurer shall be 1% of Net Premiums Earned or Premiums & Annuity Considerations reported under Nationwide Operations in the Wisconsin Insurance Commissioner's Report for business of the second preceding calendar year, subject to a requirement that the minimum bill for any insurer be \$300.

(b) For the first year of this rule the bill for any insurer, not subject to the limits established in paragraph (a), shall not exceed 150% of the previously paid examination fee on an annualized basis, adjusted for inflation, and adjusted to reflect all costs referred to in subsection (5). Thereafter, the annual bill for any insurer shall not exceed the previous year's bill for that insurer, adjusted to reflect the proportionate annual increase in the cost of examinations for all insurers, by more than 25%.

(9) ANNUAL HEARING. The commissioner shall annually schedule a hearing under section 601.41 (5), Wis. Stats., to review problems in the area of examinations, and the formulas established for the 4 categories of insurers under subsection (7) (c).

(10) DUE DATE. Amounts billed to domestic insurers under subsection (4) shall be due and payable to the commissioner no later than March 1 of each year.

**Note:** The approach taken in this rule for the development of an annual billing structure for examination costs of domestic insurers attempts to balance the historical examination experience of individual insurers with a statistically-determined approximation of what insurers of a certain premium (or asset) size would have paid.

Any approach to this task must, of necessity, contain elements of arbitrariness and human judgment. The parameters established in the rule are attempts to guard against drastic departures from past experience.

The idea to develop formulas, based upon premiums (and/or assets), to statistically explain the "line of best fit" of examination costs, grew out of the work of the McKinsey study for the National Association of Insurance Commissioners ("Strengthening the Surveillance System," 1974), and the simple observation that there should be some relationship between examination costs and the premium volume or assets of an insurer. The problem then becomes one of determining that relationship.

The technique of multiple regression analysis was used to evaluate the variables and their respective weights. Data (net admitted assets, net earned premiums, or logarithmic transformations of assets and premiums) for the examinations of calendar years 1971 through 1976 was considered.

After generating formulas which minimized the sum of the squared differences from a fitted line (i.e. "explained" the line best), a number of factors were analyzed to decide which of the formulas would make the most sense to use, including:

1. the  $r^2$  factor, which measures the percentage of the total variation in examination costs which is due to their relationship with the variables in question.
2. the F-factor, which generally is the ratio of explained variability to unexplained variability.
3. the residuals, which are the difference between predicted and observed values.

The formulas selected for the first year's billings under subsection (7) (c), subject to subsection (8), are as follows:

1. Property and casualty insurers [subsection (3) (a)]:  

$$1978 \text{ Billing} = (0.675271) \times 10^{(0.7055378 + 0.4593661(\log_e P))}$$
2. Life insurers [subsection (3) (b)]:  

$$1978 \text{ Billing} = -22,005 + (1,661.13) (\log_e A) + (2.6674284 \times 10^{-5}) \times P;$$
3. Service insurers and others [subsection (3) (c)]:  

$$1978 \text{ Billing} = 1,297 + (6.4377 \times 10^{-5}) \times P;$$
4. Fraternal benefit societies [subsection (3) (d)]:  

$$1978 \text{ Billing} = 3640.0 + (1.03231098 \times 10^{-4}) \times P$$

where P = Net Premiums Earned or Premiums & Annuity Considerations reported under Nationwide Operations in the 1977 Wisconsin Insurance Commissioners Report (Business of 1976)

A = Admitted Assets reported in the 1977 Wisconsin Insurance Commissioners Report (Business of 1976)

\* \* \*

The estimated percentages of total regular examination costs under subsection (7) (b) based on the triennialized last examination cost for each company, and excluding town mutuals were as follows:

1. property and casualty, 52.0%;
2. life, 32.8%;
3. service insurers and others, 6.7%; and
4. fraternal, 8.5%

A "full cost of examinations conversion factor" for the initial billing utilized in subsection (8), was set at 1.5873 based on analysis of historic examination and budgetary experience, and the factor to adjust for inflation was set at 1.11 for years immediately prior to 1977 and at 1.09 for the calendar year 1977.

**History:** Cr. Register, December, 1977, No. 264, eff. 1-1-78.